once again, when we think of Senator WARNER—I will have more to say about him in the days ahead—Senator KENNEDY has spoken for all of us this morning as he talked about how much we value Senator WARNER's counseled insight. I want him to know how much I appreciate his leadership and how much I value his counsel in the Senate.

Mr. KENNEDY. I thank the Senator.

Mr. WYDEN. Mr. President, I know we are in morning business. I ask unanimous consent to speak on the health care issue for up to 20 minutes.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE

Mr. WYDEN. Mr. President, Senator BENNETT of Utah and I have brought to the Senate the first bipartisan universal health care coverage legislation in more than 13 years. I thought today I would open my remarks on health care in something of a light fashion. There is a brand new study that has recently found Americans are no longer the tallest people in the world. Over the past 50 or so years, the U.S. population has lost that status and now ranks among the shortest among industrialized countries. The Netherlands now holds the honor for the tallest nation. The authors of this new study speculate this change may stem from the fact that most other affluent countries have health care systems that cover their entire population and that particularly healthy lifestyles and healthy diets are also significant factors.

Senator BENNETT is 6 foot 6. I am 6 foot 4. We would like our country to get its rightful position back as the leader among nations in the height department. We think part of what is going to be necessary to do that, in all seriousness, to make our health policies more health focused rather than just spending on health care, is to adopt some fresh policies. We have been particularly interested this week because the Wall Street Journal, which colleagues know displays a preference for private health care sector solutions, has written a fascinating front page article this week on the special accomplishments in Holland with respect to health care. I have long been of the view that as we look finally to accomplishing what this country has not been able to do for 70 years, which is to get all Americans good quality, affordable health care, we are going to have to devise our own system. It is not going to be possible to import some other country's system of health care to our Nation and pretty much plop it down on the United States and say: This is the way to go.

But as the Wall Street Journal said in their article this week, there are some important lessons to learn as it relates to the experience of other countries.

I ask unanimous consent to print in the RECORD this front page article from the Wall Street Journal with respect to health care.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

IN HOLLAND, SOME SEE MODEL FOR U.S. HEALTH-CARE SYSTEM

(By Gautam Naik)

THE HAGUE.—The Netherlands is using competition and a small dose of regulation to pursue what many in the U.S. hunger to achieve: health insurance for everyone, coupled with a tighter lid on costs.

Since a new system took effect here last year, cost growth is projected to fall this year to about 3% after inflation from 4.5% in 2006. Waiting lists are shrinking, and private health insurers are coming up with innovative ways to care for the sick.

The Dutch system features two key rules: All adults must buy insurance, and all insurers must offer a policy to anyone who applies, no matter how old or how sick. Those who can't afford to pay the premiums get help from the state, financed by taxes on the well-off.

The system hinges on competition among insurers. They are expected to cut premiums, persuade consumers to live healthier lives, and push hospitals to provide better and lower-cost care.

Some are already taking unusual steps. The insurance company Menzis has opened three of its own primary-care centers to serve the patients it insures, and plans to open dozens more in a move to lower costs. Rival UVIT offers discount vouchers to customers who buy low-cholesterol versions of yogurt, butter and milk.

To prevent insurers from seeking only young, healthy customers, the government compensates insurers for taking on higher-risk patients. Insurers get a ''risk-equalization'' payment for covering the elderly and those with certain conditions such as diabetes. to pay her back about $676 for gym membership—provided Ms. Boel lost 7.5% of her weight in 15 months.

The 45-year-old, who lives in the town of Tilburg, says she stopped eating french fries and pizza and took up an intensive regimen of walking, cycling and rowing. She met her weightloss target and used the gym-membership rebate to buy some new clothes.

Ms. Boel now hopes to manage her diabetes more efficiently and lose more weight. ''I don't like exercising,'' she says, ''but at least I can now walk without a stick.'' That's welcome news to UVIT. Says spokesman Bert Rensen, ''Once she stops using insulin, which we pay for, it will save us £900 [about $1,200] a year.''

LIKELY OPPOSITION

What works in the Netherlands, a small country of 16.6 million people, may not readily apply to America. A Dutch-style scheme would likely raise opposition among U.S. doctors and Republicans who are cautious about higher taxes. But many U.S. states are similar in size, and one, Massachusetts, is already experimenting with a universal-coverage scheme.

''The lesson for America is that this is what we ought to do,'' says Alain Enthoven, a professor at Stanford University.

Three decades ago, Prof. Enthoven published a pioneering proposal for what he called ''managed competition,'' a version of which the Dutch have now adopted.

The Enthoven plan partly inspired the Clinton administration's failed health-care overhaul effort in the 1990s. It has now come full circle. Last October, an economist from the Dutch health ministry was invited to describe his country's new approach to about 50 Massachusetts politicians and policy makers in Boston, as the state was developing its own plan for mandatory health insurance.

After being sidelined for more than a decade, health care is once again a hot issue on the U.S. political agenda. Two leading Democratic presidential candidates, Sen. Barack Obama of Illinois and former Sen. John Edwards of North Carolina, have backed the idea of universal coverage and suggested ways to achieve it. California Gov. Arnold Schwarzenegger, a Republican, has pushed a proposal to require all state residents to obtain health insurance, but he hasn't been able to strike a deal with state legislators to enact a plan.

The notion of competition among insurers is nothing new to Americans. Most Americans under 65 get insurance via their employer, which can compare plans and pick the one that it thinks offers the best coverage for the money. To cut costs, U.S. insurers bargain with doctors for discounted rates and try to weed out overbilling and frivolous treatments.

The system has failed to stop U.S. health costs from shooting up, and it has left many doctors complaining that their medical judgment is being second-guessed by bean counters. It isn't clear that a Dutch-style system, also centered on insurer competition, could do any better. Dutch doctors were among the most vociferous opponents of an overhaul and many remain skeptical.

Still, there are some differences in the Dutch way that may work to its advantage. One is the emphasis on individuals buying coverage. In the U.S., employers tend to be poor buyers of health care. They're unfamiliar with the needs of the people actually using the health care—their employees—and it is difficult for a large company to switch insurers.

By putting the onus on consumers, Dutch officials hope that more people will get the coverage they need. The ''risk equalization'' that helps Dutch insurers cover sicker people is also critical. In the U.S., competition among insurers often means competition to find the healthiest customers, especially in the individual market.

The Netherlands began to overhaul its health system in 1987 after a government committee concluded that the best approach was ''managed competition,'' the idea first proposed by Prof. Enthoven of Stanford.

The task was enormous. The country had four different coverage schemes. The wealthiest third of the population was required to get health insurance without government assistance. Some in this group received help from employers in paying premiums, while others paid the whole bill themselves. The bulk of the Dutch population was covered under a compulsory state-run health-insurance scheme financed by deductions from wages. Civil servants and older people were insured under two separate plans within this state-run scheme.

The government closely regulated hospital budgets and doctors' fees, but provided few incentives to cut costs. When hospitals lost money on a particular kind of care, they rationed it. Many patients ended up on waiting lists.

People in line for heart transplants were particularly affected. In the mid-1990s, fewer than three Dutch people per million received such transplants. By comparison, a study of 12 European countries showed that only Greece had a lower rate of such operations. In the U.S., there were about nine heart transplants per million people.

In 1999, waiting lists increased by 2%, despite a $54 million initiative to reduce them. ''Dead on the waiting list,'' read one cover story of Vrij Nederland, a weekly magazine that, like other Dutch media, relentlessly criticized the country's health system.

''We felt frustrated,'' recalls Hans Hoogervorst, who was the health minister from 2003 to early 2007 and a major force in pushing through the overhaul.

Though the Dutch still enjoyed better health than the residents of many developed countries, standards were slipping. Between 1960 and 2000, the increase in Dutch life expectancy was 4.5 years, while its neighbors, Germany and Belgium, showed far better increases of 8.1 and 7.1 years, respectively, according to the Organization for Economic Cooperation and Development. In the U.S., the increase was nearly seven years.

As in the U.S., medical costs began to increase, driven by an aging population and the increased use of expensive new technology. Between 2000 and 2004, Dutch health spending as a share of gross domestic product shot up to 10% from 8%.

In late 2004, the Dutch House of Representatives passed a law to usher in mandatory health insurance and switch people on state-run insurance to private carriers. But family doctors fretted that it would allow insurers to interfere in medical decisions, for example by pushing cheaper drugs.

The following May, thousands of Dutch general practitioners went on a three-day strike. Some tied their hands together with rope to symbolize their helplessness. In response, Mr. Hoogervorst promised to provide some protections for doctors in the new legislation. One of them was that patients wouldn't bear a big financial cost if they chose to go to a doctor not under contract with their insurer. Soon after, the senate approved the new plan.

It took effect on Jan. 1, 2006. Despite predictions of chaos, the changeover was surprisingly smooth. The government set up a Web site where consumers could analyze insurers' offerings. Consumers were allowed to switch insurers once a year. As 2006 approached, the health ministry predicted that only 5% would bother. Instead, nearly 20% of people switched, either to get a better price or because they were dissatisfied with their insurer.

PREMIUM WAR

Consumers also benefited from a premium war as insurers made a grab for market share. The Dutch health ministry had predicted that insurers in 2006 would price the annual mandatory premium at an average of £1,106, or about $1,500. Instead, market forces set it at £1,028, 7.6% lower. This year, it has risen to £1,103, partly because of an easing in the price war. That's still less than the £1,134 the government predicted for 2007.

Included in the overhaul was a deal the government negotiated with generic-drug makers to cut prices by about 40%. The generic-drug makers made up for some of their lost revenue by reducing the rebates and bonuses they provided to pharmacists to recommend their drugs to customers. From 2004 through 2006, annual drug spending grew at an average annual rate of 2.8%, down from 9% annual growth earlier in the decade.

Insurers have taken a hit, though. UVIT, which has more than four million customers, was forced to open a 200-person call center to help consumers switch between plans. In 2005, UVIT had total revenue of about $7.6 billion and made a profit of about $202 million from health insurance, which is its main business. Last year, the company's health business posted a loss of $30 million. UVIT expects to return to profitability this year, partly by negotiating lower prices with hospitals.

In most European countries, consumers have no idea what their health insurance costs because they are covered by national health-insurance schemes financed by payroll taxes, as used to be the case in the Netherlands. On a visit to Germany last year, Mr. Hoogervorst boasted that thanks to his country's switch to private insurance paid by individuals, ''no other European country has a population so keenly aware of the costs of their health-care insurance.''

Now that they see the bills more clearly, some consumers feel their payments have gone up. In one survey mainly of labor-union members, about 70% said they were financially worse off in some ways.

Insurers get risk-equalization payments for patients with about 30 major diseases. They can use these to offer discounted premiums and programs tailored to those with heart disease, diabetes and other ailments.

One shortcoming is that many diseases aren't subject to risk equalization. The excluded diseases—such as migraine headaches—are harder to diagnose and their treatment costs are harder to predict. ''Seen from the side of migraine patients, this is highly unfair,'' says Peter Vriezen, president of the Dutch Headache Patients Association.

The real test of the Dutch approach is yet to come: Can insurers push hospitals to lower their costs and improve their quality? Insurers have clout because they can direct large numbers of patients toward particular hospitals. But, in a holdover from the old system, insurers can currently negotiate prices * * *. The figure will rise to 20% by the end of this year, and continue to go up.

Because Dutch hospitals used to receive fixed prices for their services, and got more money for more service regardless of quality, they had little incentive to improve their care. Under the new system, insurers should be providing that incentive, but Mr. Hoogervorst acknowledges, ''Thee's still a long way to go to increase competition among hospitals.''

MARKET INCENTIVES

One concern is the potential for overconcentration among insurers. UVIT, for example, is the result of a merger between four insurers. ''If eventually you have only three or five insurers, you might wonder how many market incentives will remain,'' says Niek Klazinga, professor of social medicine at the University of Amsterdam.

Last fall, Prof. Enthoven delivered a speech to health economists in Rotterdam. He congratulated the Dutch for being ''in the lead'' in health-care change. However, he cautioned, ''you still have considerable work ahead of you to transform your present success with insurance'' into a system that delivers improving care.

Some insurers are taking unusual steps to get there. Menzis rewards doctors with bonuses if they prescribe generics instead of more expensive branded drugs. UVIT ranks hospitals based on the quality of care.

To put pressure on Dutch hospitals, some insurers let patients go to other countries where high-level care for certain ailments costs less. Thea Gerits, 71, went to Germany for a hip replacement and spent four weeks in a rehabilitation center there, receiving physical therapy and enjoying yoga, massages and mud baths.

UVIT paid the $19,000 bill. It says the same amount in the Netherlands would buy only the surgery and basic therapy. Ms. Gerits came home happy, and soon was riding her bicycle again. ''I got lots of attention,'' she says. * * *.

Mr. WYDEN. I am going to read one paragraph at the outset of the article:

Since a new system took effect here last year, cost growth is projected to fall this year to about 3 [percent] after inflation from 4.5 [percent] in 2006. Waiting lists are shrinking, and private health insurers are coming up with innovative ways to care for the sick.

What struck Senator BENNETT and I is, there is an awful lot of comparison between our bipartisan legislation and the experience of the Dutch. For example, both in Holland and in the United States under our proposal, there would be a requirement that individuals would have to purchase their own health insurance. Insurers under our proposal, as in Holland, would not be able to discriminate against individuals who have had illnesses. We saw in the movie ''Sicko'' that wonderful scene with the ''Star Wars'' music describing all the various conditions that individuals might have that would exclude them from insurance coverage. That would be illegal under what Senator BENNETT and I are advocating. It is illegal, according to the Wall Street Journal, in the Netherlands.

Finally, in the Netherlands and under our legislation, there is a sharp and specific focus on prevention and wellness. The tragedy in our country is, we don't have health care at all. What we largely have is sick care. Medicare shows this probably more clearly than anything else. Medicare Part A will pay huge expenses for senior citizens' hospital bills. The check goes from the Government to the hospital. But Medicare Part B, on the other hand, will pay for virtually nothing for prevention and keeping people well. Senator BENNETT and I seek to change that. For the first time under our legislation, Medicare would be authorized to discount the premiums for seniors who lower their blood pressure, lower their cholesterol, practice good health in their individual lives. I am struck by this Wall Street Journal article, where insurers in Holland are adopting much the same kind of approach. The article states on the front page that insurers now are offering discounts to customers who buy low cholesterol versions of yogurt, butter, and milk.

The point is, worldwide the message is getting out. Prevention works. Wellness, a new focus on personal responsibility, and keeping our citizens healthy makes sense. They are doing it in Holland. The Wall Street Journal describes the positive benefits there. I and Senator BENNETT, along with our cosponsors, Senators BILL NELSON, LAMAR ALEXANDER, and JUDD GREGG, are trying to build a bipartisan coalition in the Senate to do exactly the same.

Our legislation, the Healthy Americans Act, would require that everyone not on Medicare or in the military would have to purchase private health insurance. But to make sure that is doable, we fix the broken marketplace. Under our legislation, private insurance companies wouldn't be able to cherry-pick. They wouldn't be able to take just healthy people and send sick people over to Government programs more fragile than they are. They couldn't discriminate against those with illnesses. They would have to spread risks through large groups of people. Right now essentially much of the private insurance business is about

filtering out those people who have illnesses and finding a way to cover just those who are healthy. Our legislation would change that.

We also take critical steps to make sure that if you are going to require that people purchase coverage, you have generous subsidies for folks with modest incomes. What Senator BENNETT and I propose—and apparently they are doing something along these lines in Holland—is to subsidize those up to 100 percent of poverty completely and for those between 100 percent of poverty and 400 percent of poverty, there would be a partial subsidy. The most generous subsidies of any program anywhere in our country would be offered under this legislation that we are offering, with Senators ALEXANDER, GREGG, and NELSON of Florida.

How do we pay for it? The Lewin Group, which is kind of the gold standard for looking at health policies, scored the administration's approaches, many of the States and ours and said we can find a lot of the savings under our legislation through an administrative process that establishes that once you sign up in Ohio, once you sign up in Oregon or anywhere else in the country, you are in for life. You don't have to sign up again and again and again. In my State, my guess is it is very similar to the situation in Ohio, if you are on Medicaid, there is something like 31 or 32 categories of coverage. A poor person has to try to squeeze themselves into one of those boxes in order to get coverage. It is degrading to the poor and a big waste of money.

What Senator BENNETT and I have offered is a one-stop process so you sign up once, and everything else from that point on is essentially accomplished through the magical world of electronic transfers. An individual's contribution would be taken out of their paycheck while they are working. Ours is fully funded.

There is an opportunity for bipartisan cooperation, particularly should the Bush administration want to assist in this effort. For example, every single economist who has come before the Finance Committee, before the Budget Committee, has talked about the Tax Code as it relates to health care disproportionately favoring the most affluent and rewarding inefficiency at the same time. To put it another way, if you are a high-flying CEO in the United States, if you want to go out and get a designer smile put on your face, you can write off the cost of that service on your taxes. But if you are a hard-working woman without any health plan and a local furniture store, you get nothing. So I and Senator BENNETT redirect the current tax expenditures. They are the biggest part of private health care spending.

The Lewin Group establishes in their analysis of our report that would ensure we could expand coverage over the next few years without any additional cost to taxpayers. The Lewin Group has said the proposal now being sponsored by five Members of the Senate would slow the rate of growth in health care spending by $1.5 trillion.

I know the distinguished Presiding Officer has a great interest in health. We are so pleased he is here because we have worked together on these issues often. It is clear this is the premier domestic issue of our time. A combination of today's demographics with a rapidly aging population, escalating costs, the huge increase in chronic illness, our current health care system is not sustainable. It is not one we can put on automatic pilot and say: Let us run it this way for years and years in the future.

The tragedy is with all the wonderful doctors and hospitals and nurses in Ohio and Oregon, all across the country, we are spending enough money on health care to do this job. We are simply not spending it in the right places.

To give an idea of how out of whack American health care spending is, for the amount of money we are spending today, $2.3 trillion, 300 million of us in the country, you divide 300 million into $2.3 trillion, and you could go out and hire a doctor for every seven families in the United States and say: Doctor, your job will be for this year to take care of seven families, and we will pay you $200,000 a year.

My experience, I say to the Acting President pro tempore, is that when I bring this up to physicians at home in Oregon, they say: Ron, where do I go to get my seven families? It sounds pretty good to be able to get back into the business of practicing medicine again and advocating for my patients rather than going through all this paperwork and bureaucracy and redtape.

So we are spending enough on health care today. We are not spending it in the right places. That is what they have begun to change in Holland, according to the Wall Street Journal this week. That is what I and Senator BENNETT and our colleagues on both sides of the aisle are seeking to do in the Senate.

One last comment, Mr. President. I know there is a hectic schedule for all Senators, and certainly the Senator from Ohio.

The question is whether there should be action now or the Congress should simply wait for another Presidential election. Here are the consequences of waiting for several more years. The Census Bureau reported last week that 2.2 million additional Americans were without health insurance between 2005 and 2006. If this Congress waits a couple of years more, we can expect that number to increase and the number without coverage in this country to hemorrhage further.

That is a moral abomination, No. 1; and it is going to be costly to taxpayers, No. 2, because those people very often will have to go to hospital emergency rooms to get their coverage. Of course, those bills will be passed on to businesses in Ohio and Oregon and across the country and to our taxpayers. So the costs of delay are very direct and immediate.

Second, with respect to employer-based coverage, the new numbers indicate the number of employers offering coverage has now fallen below 60 percent. It is pretty easy to see why, with these double-digit premium hikes, Price Waterhouse says health costs are going to average, this year, a little over 11 percent. A lot of our employers want to do the right thing by their workers and simply cannot offer coverage.

If this Congress decides to stand down on the question of overhauling health care and say, ''Let's just wait until 2009,'' you are going to see more businesses in Ohio, in Oregon, and across this country lose coverage. I do not think we ought to sit by and just let our coverage continue to melt away along the lines of these statistics that I mentioned.

Finally, on the question of prevention and what Holland is doing, and what we are seeking to do in the Healthy Americans Act, there is a very significant cost with respect to chronic illness as it relates to doing nothing to change our policies. The new numbers with respect to chronic illness indicate that in 31 States over the last year obesity has risen once again; of course, there is a direct link here between heart and stroke and diabetes and so many illnesses. Not one State—not one—experienced a decline.

So if the Congress says: Well, we will pass on overhauling American health care until 2009, we can expect to have missed another opportunity—yet another opportunity—for doing something about enacting health care policies that put a new focus on prevention and wellness.

So this question of waiting for 2 more years and saying: Let's just spend our time looking at what the various candidates for President from both political parties are saying about health care—certainly it is getting a lot of attention in terms of debates on TV and all of us trying to look at the various merits of the candidates' proposals; and they are good people; and they have good suggestions—but I want to make it clear to the Senate there are very real costs of waiting to fix health care.

I think the question of fixing health care is so urgent we ought to get on with it, and we ought to get on with it in a bipartisan way, which is what I and Senator BENNETT are trying to do. We are very proud to have been able to get the support of business and labor leaders.

When we offered the initial proposal, Andy Stern, the president of the Service Employees International Union, stood on one side of me, and Steve Burd, the CEO of the Safeway company, a very large Fortune 500 company, stood on the other side. We had individuals such as Ron Pollack, of

Families USA, and advocates for compassionate end-of-life health care with us as well.

The last time Congress looked at this—and the Acting President pro tempore, I think, remembers this—during a period in the early 1990s, the people who stood with me for the kickoff of the Healthy Americans Act were spending millions to pretty much beat each other's brains out. That was the last time the Congress and the President, during the Clinton years, debated health care.

So this is a different climate, certainly a different climate for businesses in Ohio and Oregon. What I hear from businesses at home—unlike in 1993, the Clinton years, when they said: We cannot afford fixing health care—they are now saying: We cannot afford the status quo. That is why they are joining Senator BENNETT and I and others on these proposals.

My hope is as Congress looks at the evidence, whether it is the Wall Street Journal reporting on promising developments—very often people think of Europe and socialized countries—the Wall Street Journal is putting on the front page of the paper—a publication that clearly favors private health care coverage—an example of a country in Europe where they seem to be making great progress.

So as we devise our own system, one that is uniquely American, I and Senator BENNETT want to work with every Member of the Senate—I think I can speak for Senators BILL NELSON, LAMAR ALEXANDER, JUDD GREGG, and the others we have been talking to—that we think this is the premier domestic issue of our time. Certainly, the conflict in Iraq is the premier national security issue. But the premier domestic issue at home is fixing American health care.

I think based on the evidence that comes in every day, we know what needs to be done. Now the question is making sure there is the political will to go forward. I look forward to working with the Acting President pro tempore, who has a great interest in these matters, and all our colleagues.

Mr. President, I yield the floor.

Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BROWN. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. CASEY). Without objection, it is so ordered.

TUBERCULOSIS

Mr. BROWN. Mr. President, every day an estimated 4,400 lives are lost around the world to tuberculosis—day in, day out, yesterday, today, and tomorrow. Fifteen lives will be lost, roughly, in the few minutes of my remarks.

Tuberculosis is an urgent global crisis that demands our attention and our response. Two billion people—two billion people—one-third of the world's population, carry around with them the tuberculosis bacterium. As many as 10 million to 15 million in the United States alone are infected with the TB bacterium. Most will not get sick, but many of them are in some jeopardy.

Nine million people, practically the population of my State of Ohio, become sick with active tuberculosis every year, and 1.6 million people will die.

We struggle with many diseases that are beyond our scientific understanding, but tuberculosis is not one of them. These deaths are preventable. TB is the greatest curable infectious killer worldwide.

Much of the good work of the legislation this Senate passed last night will be undermined if we do not do a better job of controlling tuberculosis. Our investments in development will do little to improve economic conditions if entire populations—as are so many in Africa, especially, and India, especially—are reeling from this disease.

Combating TB is fundamental to sustaining economic development in poor countries. My colleagues know this.

Congress—following the leadership of the Foreign Operations Subcommittee Chairman, PAT LEAHY, and ranking member, JUDD GREGG—has made great strides in investing greater resources in global health. Diseases such as HIV and malaria have received tremendous increases over the past several years, and I hope this trend will continue.

Last night, the Senate did something about this. The amendment I offered last night, with Senators BROWNBACK, DURBIN, BOXER, and SMITH, added $90 million in funding for our international efforts against tuberculosis, bringing total spending to $200 million. Undoubtedly, that will save lives.

Combating TB must go hand in hand with the fight against HIV. Up to 50 percent of people who are HIV positive develop tuberculosis. As many as half the deaths from HIV in Africa actually are deaths from tuberculosis. It is the leading cause of death among people who are HIV positive all over the world.

HIV infection weakens a person's immune system, making it 50 times more likely that person will develop active tuberculosis. So if someone is carrying the TB bacterium in their body—as is a third of the world's people—if they get infected with HIV or have some other disease or weakness—from malnutrition or something else—they are much more likely to develop active tuberculosis.

To compound that, unchecked, drug-resistant tuberculosis, including deadly XDR-TB, threatens to reverse progress made against AIDS and TB worldwide. In today's world, extensively drug-resistant TB—so-called XDR-TB—poses a grave public health threat never more than a plane ride away.

This past June, we got a wakeup call when an American boarded a plane to Europe while infected with drug-resistant tuberculosis. Luckily, his was not the most virulent strain. But his example shows us clearly that this disease does affect America and that more resources for TB are needed to prevent, identify, treat, and control extensively drug-resistant tuberculosis.

We need to heed that wakeup call and act before it is too late. It is within our power. There is no mystery here. We know what to do. We know how to treat and cure regular so-called garden-variety tuberculosis. We know how to treat and cure multidrug-resistant tuberculosis in an overwhelming majority of cases. And we know how to treat, generally, extensively drug-resistant—XDR-TB—tuberculosis and cure people of that. It is within our means. Treating regular, garden-variety TB costs only $20 per person. It is a small price to pay to save our lives.

I thank my colleagues, including the junior Senator from Pennsylvania for his support of this issue. Last night was a victory for people in the developing world who are so often victims of tuberculosis, who so often suffer from that. It is also a victory for people in our country, a few of whom have TB, but most—but the many more people who are a plane ride away or are potentially exposed to this tuberculosis bacteria.

I thank my colleagues.

FOREIGN OPERATIONS APPROPRIATIONS

Mr. FEINGOLD. Mr. President, I strongly oppose coercive abortion or involuntary sterilization, and was pleased that the fiscal year 2008 Foreign Operations Appropriations bill included a provision prohibiting U.S. funds from going to any organization or program that directly supports such horrific practices. Unfortunately, the amendment offered by Senator BROWNBACK undermined this provision by allowing the President to deny funds to any organization or program that he claims supports such practices. This administration has misused similar language to deny resources to the United Nations Population Fund simply because this agency has programs in China, where the government practices coercive abortions to enforce its one child policy. In fact, however, the UNFPA's program in China is specifically designed to pressure the Chinese to end the use of coercive tactics, and this amendment would undermine the good work that the UNFPA does.

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

• Mrs. CLINTON. Mr. President, as we consider legislation to provide funding for our important international development and assistance programs, I would like to take the opportunity to highlight the issue of quality basic education and the ways in which increasing access to basic education can improve social, economic, and health